DEI Committee

Notes on Draft DEI Plan

DEFINITIONS

DIVERSITY v 1.0.1
RATIFIED 10/12/2022

This is a living document, and will never be complete.

Précis: The OHSU-PSU School of Public Health operates with a definition of **diversity** as the prioritization of representation by historically oppressed and marginalized groups, both in practices shaping the composition of our student, administration, and faculty bodies and structures, and in the centering of perspectives from them in the routine course of our collective work. We adopt this definition of diversity as a primary operating value in order to best accomplish our vision of promoting a healthy, equitable society.

Background and history: Diversity, or its lack, is a group characteristic, not an individual characteristic. While, as suggested by the NIH, diversity could mean "a group comprised of people from different [defined *a priori*] genders, races/ethnicities, cultures, religions, physical abilities, sexual orientations or preferences, ages, etc.," this definition excludes historically oppressed and marginalized groups which have not been officially recognized. Some examples include Indian tribes unrecognized by the governments of federal, state, or Indian nations, and, the absence of official recognition of transgender or gender minority groups by the NIMHD until 2016. Another example of the approach taken by the NIH includes health-related workforce efforts promoting diversity for/among specific population groups that are evidenced to be underrepresented in the field—these specifically include individuals from certain racial/ethnic backgrounds, individuals with disabilities, individuals from lower socioeconomic backgrounds, and women. Consider that while in recent decades white heterosexual cisgender men have been underrepresented within many MPH degree programs, the OHSU-PSU SPH's definition of diversity would not prioritize their representation because this is not a historically oppressed or marginalized group, whereas definitions of diversity predicated on reproducing the demographics of the wider society would prioritize their representation.

Efforts to promote or improve diversity have relied almost exclusively on the use of vetted social categories that define dimensions of difference between groups of people that officially matter. However, pursuit of "checking off" official social categories on such lists is fundamentally misguided in the absence of attention directed to why the items are on the list to begin with; compliance does not confront power in the service of oppression and marginalization. For example, the OHSU-PSU SPH cannot—and will not—improve diversity in regard to race without explicitly accounting for and redressing racism (institutional and interpersonal)—both historic and present, and both intra- and extra-institutionally. While "lists" are of instrumental and practical value, they offer little in regards to *productive* value if not coupled with explicit considerations of *presence* and *representation*, and critical examination of historic and present factors that may lead to certain expressions of diversity being present (and *remaining* present) more than others. Therefore, while received lists of officially recognized social categories offer guidance and precedent as to what "counts" as diversity, the DEIC operates under the below set of tenets and commitments.

Our values and vision

1) **The DEI Committee, and the work conducted and produced therein, will not endorse or take a generic list of differences, social identities, or characteristics as its singular orientation to promoting or counting "diversity."**
   - Promoting diversity requires explicit acknowledgment of historic and current mechanisms of oppression and marginalization which have created the present circumstances wherein calls for greater diversity are necessary to begin with—both for the health of the public health field and for the health of the public.
   - Mechanisms of oppression and marginalization have included white supremacy, structural racism, sexism, heteronormativity, settler-colonialism, ableism, and classism among other mechanisms. With humility, we believe that there will always be an "among other mechanisms," so such lists must always be provisional and incomplete maps of the ways oppression and marginalization operate. Such mechanisms have functioned *simultaneously* to systemically preclude certain *populations* (not individuals) from fair opportunities in social, economic, political, and educational domains of life.
   - OHSU-PSU SPH students, faculty, and administration are either present or absent based, in part, on how these layered systems have either impeded or supported their ability to hold this space based on their belonging to various and *multiple* populations defined by different categories of social experience across their life course.
   - Singular social categories, whether demarcated by characteristic, position or identity, are incapable of representing the interlocking nature of histories of layered social experiences, and thus incapable of rendering transparent the systems that produce "differences" across and within such social categories—both in regards to health and in regards to representation within the OHSU-PSU SPH.
   - The DEI thus embraces an **intersectional lens** in defining and pursuing its work in regards to diversity, and as such, will not anchor itself to reductionist efforts to "count" diversity via a series of disconnected, theoretically unsubstantiated, and conceptually flawed "boxes."

2) **The DEI Committee expressly rejects pervasive racial capitalist orientations to promoting diversity that, by definition, aim to derive social or economic value from exhibiting counted bodies of color.**
   - This practice is robustly manifest in marketing and branding materials and practices, as well as in the fact that this very committee is composed of an "overrepresentation" of people of color—tasked with improving diversity in a manner that is inextricably linked to increasing programmatic and institutional valuation (both social, e.g., brand, image, prestige; and economic, e.g., increased enrollment). Such institutional valuation accrues via commodification of the identities, culture, labor (e.g., this committee) and presence of bodies of color—therefrom used to signal a brand of "diversity" that appeals to largely white consumers (here, students, faculty, administration, and donors).
   - Faculty, students, and staff from any historically (and presently) oppressed and marginalized groups must contend with and within an institutional space wherein their presence adds institutional value, yet often simultaneously subtracts individual health and well-being. This violates manifold principles of social and distributive justice, and, importantly, fundamentally curtails efforts to promote (and *sustain*) diversity.
   - We accordingly will not develop, support, or endorse any SPH program, policy, or practice that fails to: a) expressly engage these considerations, and b) meet them with accordant institutional resources so as to minimize blatant exploitation of labor and cultural capital.

3) **The DEI Committee endorses an articulation and approach to promoting diversity which expressly centers *intersectional and relational histories* of social, economic, and political power—embodied and manifest vis a vis health inequities and evidence thereof.**
    - We resist generic, all-encompassing definitions of diversity that implicitly equate all forms, expressions, and markers of difference, such that efforts to promote and improve diversity are diffuse, ahistoric, and decontextualized.
    - We support diversity efforts that explicitly and unapologetically prioritize greater representation of and for individuals from populations that have historically and presently experience the greatest health inequities—*from an intersectional and relational lens*. For example, a poor, straight, white, Christian male student and a wealthy, gay, black, Muslim female student are not exchangeable—and our assessments of how to promote diversity must explicitly account for how the presence of the former has historically precluded the presence of the latter.
    - We submit that promoting diversity requires a *diversity of specific, deliberate, and targeted strategies* confronting power in the service of historic and ongoing oppression and marginalization, but which are not arbitrarily delimited by general population demographics. As an example specific to OHSU-PSU School of Public Health, both campuses exist on lands stolen through racialized, settler-colonial violence that resulted in large-scale spatial dispossession, death, trauma, and political and economic disempowerment. Thus using general population demographics of native and indigenous peoples as a guide for "success" presents as a robustly asinine, ahistoric, and reckless act of epistemic violence.
    - As such, DEI's orientation to diversity will reflect core principles and considerations articulated via **critical race theory** and **targeted universalism**.

Our process to produce this

This definition reflects collaborative work informed by the scholarship and lived experiences of faculty occupying and embodying the margins of racial & ethnic identity, sexual orientation, gender, and economic power, as well as intersecting with experiences of whiteness, heterosexuality, cisgender experience, and economic privilege. This labor appears to be unrecognized by the wider OHSU-PSU SPH community and leadership for the burden of its production, and especially for the experiences of violence and exploitation to which it is a response.